

AMBULATORY SURGICAL CENTER REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Please see statement on reverse and read the following instructions before completing this form)

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions of Coverage are met. Assistance in completing the form is available from the State agency.

Answer all questions as of the current date. Return the original and first two copies to the State agency; retain the last copy for your files. If a return envelope is not provided, the name and address of the State agency may be obtained from the nearest Social Security Office.

Detailed instructions are given for questions other than those considered self-explanatory.

Medicare Supplier Number - Insert the facility's six-digit supplier number. Leave blank on initial requests for certification.

Related Provider Number - Complete this block when a facility is participating under more than one provider number, such as a facility also

participating as a hospital. The number in this block for each related provider will be the provider number of the highest level of care.

NOTE: If an ASC is operated by a hospital, has a Distinct Part SNF, ICF and ICF/MR, the related provided number field on the application for each provider (including the hospital) will have the hospital provider number.

State/County and State Region Codes - Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.

Item III - If a service is provided directly by the facility, place a '1' in the appropriate block. If a service is provided through an outside source (i.e., by contract or referral), place a '2' in the appropriate block.

Item IV - 'X' the appropriate blocks representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties).

Medicare Supplier Number AS1		Related Provider Number AS2		State/County Code AS3		State Region Code AS4		Fiscal Year Ending Date AS5	
Name of Facility		City, County, and State		Zip Code		Telephone No. (Include Area Code)			
I IDENTIFYING INFORMATION		1. <input type="checkbox"/> Proprietary		2. <input type="checkbox"/> Non-Profit		3. <input type="checkbox"/> Government			
II TYPE OF CONTROL (x one box) AS7		1. <input type="checkbox"/> Laboratory		2. <input type="checkbox"/> Radiology		3. <input type="checkbox"/> EKG		4. <input type="checkbox"/> Pharmacy	
III ANCILLARY SERVICES (Place '1' or '2' in blocks) AS8		1. <input type="checkbox"/> Cardiovascular		6. <input type="checkbox"/> Ophthalmology		7. <input type="checkbox"/> Oral		11. <input type="checkbox"/> Thoracic	
IV SURGICAL SPECIALTIES (X appropriate blocks) AS9		2. <input type="checkbox"/> Foot		7. <input type="checkbox"/> Orthopedic		8. <input type="checkbox"/> Otolaryngology		12. <input type="checkbox"/> Urology	
		3. <input type="checkbox"/> General		8. <input type="checkbox"/> Plastic		9. <input type="checkbox"/> Other (Specify)		13. <input type="checkbox"/> Other (Specify)	
		4. <input type="checkbox"/> Neurological		10. <input type="checkbox"/> Plastic					
		5. <input type="checkbox"/> Obstetrics/Gynecology							
V FACILITY CHARACTERISTICS		1. Number of Operating Rooms		2. Date Center Began Providing Services					
		AS10		AS11					

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OR A REQUEST TO PARTICIPATE OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Signature of Authorized Official (sign in ink)

Title

Date

According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0266. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.